

5031

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>145 East Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DAVIS</u> Last <u>ANDERS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1905</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesclerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Max Smith</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-09-7721</u>		17. INFORMANT Address <u>Mr. James H. Smith Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>22 Apr</u> , 19 <u>58</u> , to <u>23 Apr</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>23 Apr</u> , 19 <u>58</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. J. Lusby</u>				DATE SIGNED <u>23 Apr 58</u>			
PHYSICIAN'S NAME (Type) <u>F. J. Lusby</u>				M.D. <u>23 Apr 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/25/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Pope</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 25 1953

RECEIVED

5088 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co</u> <u>Hancock Rest Home</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Cumberland Md</u> b. COUNTY <u>Allegh</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>0102-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hancock Rest Home</u>		d. STREET ADDRESS <u>Hancock Md 111 South Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Susan</u> Last <u>Appel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1883</u> , 1st <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hobday</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Shade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Hancock Rest Home</u>		Address <u>Bearinger</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old Age</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Years</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-3</u> , 19 <u>58</u> to <u>3-10</u> , 19 <u>58</u> that I last saw the deceased alive on <u>3-10</u> , 19 <u>58</u> , and that death occurred at <u>1950</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edw M. Sipple</u> M.D.		ADDRESS (Street, city or town, state) <u>Berkeley Springs, W Va</u> DATE SIGNED <u>4-24-58</u>	
PHYSICIAN'S NAME (Type) <u>Edw M. Sipple</u>		<u>Berkeley Springs W Va</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Allegheny County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Allegheny</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Rt 11 S.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown U.S. Rt 11 south</u>			
c. LENGTH OF STAY IN 1b <u>unknown</u>				d. STREET ADDRESS <u>House Trailer</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House Trailer</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERTA</u> Middle <u>ARIZONA</u> Last <u>ARMS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31, 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Norton, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Clent Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Hand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Fannie Childress</u>		Address <u>Martinsville, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd & 4th degree burns to entire body and extremities and head</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>9/16.0</u> DUE TO (a) <u>stating the underlying cause last.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9/16.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned when trailer, in which she lived caught afire</u>			
20c. TIME OF INJURY Hour <u>4:00</u> p. m. <u>4-12-1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>4/14/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Forger</u>				24a. REC'D BY REGISTRAR <u>APR 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Reverend</u>	
ADDRESS <u>Hagerstown, Md.</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT STATE
HEALTH ONLY

FLORIDA EXAMINER'S CERTIFICATE OF DEATH
FLORIDA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

BUREAU V. R.

APR 15 1958

RECEIVED

5032 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 Hrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				d. STREET ADDRESS <u>1324 McDowell Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOBIE CLEO BARNHART</u>				4. DATE OF DEATH Month Day Year <u>April 25 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22 1890</u>		9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stillwell Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>W.W.-1</u>		17. INFORMANT <u>Mrs Mildred T. Barnhart</u>		Address <u>324 McDowell Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis of lungs; Secondary hemorrhage;</u> <u>002X</u> DUE TO shock Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I attended the deceased from <u>April 14, 1958</u> , to <u>Apr. 25, 1958</u> , that I last saw the deceased alive on <u>Apr. 25, 1958</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>4-25-58</u>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. <u>115 N. Potomac Street</u> <u>4-25-58</u>					
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>		<u>Hagerstown, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>APR 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 29 1958

RECEIVED

5083

CERTIFICATE OF DEATH

Reg. Dist. No.

05028

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUY MONROE BARROW</u>				4. DATE OF DEATH Month Day Year <u>April 9 1958 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 5 1890 67</u> yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G. Gehr & Son</u>		11. BIRTHPLACE (State or foreign country) <u>Va. Middleway Jefferson Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Barrow</u>				14. MOTHER'S MAIDEN NAME <u>Emma Furr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-3552</u>		17. INFORMANT Address <u>Mrs Nellie E. Barrow 437 Salem Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>3 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1956</u> to <u>April 1958</u> , that I last saw the deceased alive on <u>April 9 1958</u> , and that death occurred at <u>12:25 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 W. Washington St Hagerstown Md.</u> DATE SIGNED <u>4/10/58</u>							
ACTUAL SIGNATURE <u>George Jennings</u> M.D.				PHYSICIAN'S NAME (Type) <u>George Jennings Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>			
24a. REC'D BY REGISTRAR <u>APR 15 '58</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05029

5990

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b 4 WEEKS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAPLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		e. STREET ADDRESS MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNIE Middle M. Last BEALER		4. DATE OF DEATH Month APRIL Day 24 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 30 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 7 Days 1 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEAVERTON WASH.CO.MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE WEST			
14. MOTHER'S MAIDEN NAME EMMA ARNOLD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES E. BEALER GAPLAND WASH.CO.MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 DUE TO Tobacco pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured right hip DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 2 days 8 weeks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on kitchen floor - slipped		20c. TIME OF INJURY Month, Day, Year Hour 1 p. m. 2-28-58			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Gapland Washington Md.	
21. I certify that I attended the deceased from February 21, 1958 , to April 24, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE G.W. HeVan M.D.		ADDRESS (Street, city or town, state) Boonsboro Md.		DATE SIGNED 4-25-58	
PHYSICIAN'S NAME (Type) G.W. HeVan					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 26 1958		22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY	
22d. LOCATION (City, town, or county) (State) ROHRERSVILLE MD.		23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.			
24a. REC'D BY REGISTRAR APR 30 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

APR 30 1958

RECEIVED

5991

CERTIFICATE OF DEATH

05030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN ST.				d. STREET ADDRESS MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUCY Middle MAY Last BEARD				4. DATE OF DEATH Month 4 Day 24 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1874		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL FRUSH				14. MOTHER'S MAIDEN NAME LUCY KERR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS MARY BEARD Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, fibroid 002x							INTERVAL BETWEEN ONSET AND DEATH 8 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29 , 19 52 , to April 24 , 19 58 , that I last saw the deceased alive on October 29 , 19 57 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Archie Robert Cohen M.D. 4/25/58 PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. Clear Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/1958		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE APR 28 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5034 CERTIFICATE OF DEATH

05031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 12 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle D. Last BISER		4. DATE OF DEATH Month APRIL Day 9 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEAR MIDDLETOWN FRED. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSHUA FLOOK		14. MOTHER'S MAIDEN NAME LYDIA FLOOK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. WILBUR MOSER BOONSBORO MD. R. 24		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease and exposure to cold			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient found lying on back porch on 4/9/58.	
20c. TIME OF INJURY Month, Day, Year Hour ? o. m. xx p. m. 4/9/58 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Boonsboro Wash. Md.	
21. I certify that I attended the deceased from 4/9/58 , 19 4/10/58 , that I last saw the deceased alive on 4/10/58 , 19 4/10/58 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter H. Shealy		ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 4/11/58	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 12 58	
22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.		24a. REC'D BY REGISTRAR DATE APR 15 '58	
		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

WILLIAM
BOND

BUREAU V. R.

APR 15 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05032

5035

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 766 Northern Ave.		
3. NAME OF DECEASED (Type or print) First HARRY Middle EDWARD Last BRINING, JR.			4. DATE OF DEATH Month April Day 22 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1910	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 1 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Coin Photograph Machine Co.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Harry E. Brining, Jr.			14. MOTHER'S MAIDEN NAME Sally Foltz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO. 214-09-2205		17. INFORMANT Address Mrs. Dorothy Brining Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound thru skull and thru brain (.38 Calibre revolver) DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in rt. temple region with .38 calibre revolver			
20c. TIME OF INJURY Hour 3:30 a. m. PM Month, Day, Year 4-22- 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-23-58	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/1958	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home R. Franklin Poyner		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

APR 25 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05033

5036

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>				d. STREET ADDRESS <u>Hotel Hamilton</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LeROY BURGER</u>				4. DATE OF DEATH Month Day Year <u>April 13 1958 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 13 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed State Line Pa</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Burger</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMANT <u>Robert L. Burger Laurel Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Delivery</u> <u>Open fractures left tibia & Fibula</u> DUE TO <u>Closed fracture transverse spinous process and sacral vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Dislocation symphysis pubis & left sacro-iliac joints</u> (c) <u>Retro-peritoneal hemorrhage ; shock</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 12 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>812X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian, who walked into path of oncoming car</u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour XXXX Apr. 12, 58</u> <u>4:30 p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-14-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use.

IN THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
APR 16 1958
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

537 CERTIFICATE OF DEATH

05034

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 11 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDSVILLE RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS HAGERSTOWN MD. ROUTE 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAY Middle BURKER Last		4. DATE OF DEATH Month APRIL Day 18 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 23 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) LOCUST GROVE WASH. CO. MD. U.S.A.
13. FATHER'S NAME DENTON LOWERY		14. MOTHER'S MAIDEN NAME CATHERINE THOMAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT RAYMOND BURKER HAGERSTOWN MD. R. 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mesenteris Thrombosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Hr. 11 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Wound dehiscence following exploratory laporatomy 4/7/58			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/7 , 19 58 , to 4/18 , 19 58 , that I last saw the deceased alive on 4/18 , 19 58 , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		DATE SIGNED 4/19/58	
22a. BURIAL, CREMATION, REMAINS (Specify) BURIAL	22b. DATE THEREOF APRIL 21 1958	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.		24a. REC'D BY REGISTRAR DATE APR 22 '58	24b. REGISTRAR'S SIGNATURE Al. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form 10-1-54

BUREAU W. H.

APR 22 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

05035

5038

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>6 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Virginia Ave</u>				d. STREET ADDRESS <u>1917 Virginia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>BERRY</u> Last <u>CARTER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 29 1870</u>		9. AGE (In years lost birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret red</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Fred Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Berry E Carter</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Blessing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edward Q. Carter Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, cerebral and generalized</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers</u> <u>arteriosclerosis obliterans</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>April 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>7:20A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William T. Layman</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 100 Professional Arts Bldg. 4/22/58</u>			
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>				<u>Hagerstown</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5039 CERTIFICATE OF DEATH

Reg. Dist. No. 302

05036

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>12 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>ELIZABETH</u> Last <u>COOKE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upper Fitter So Shoe Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Williamsport Wash Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Hauptman</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>173-03-3052</u>	
17. INFORMANT <u>Marion F. Cooke</u>		Address <u>808 Parke Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intracerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>58</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>4/8/58</u>			
ACTUAL SIGNATURE <u>William T. Layman</u>		M.D. <u>100 Professional Arts Bldg.</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5092 CERTIFICATE OF DEATH

Reg. Dist. No.

05037

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE		d. STREET ADDRESS S. MARTIN	
3. NAME OF DECEASED (Type or print) First CHARLES Middle FUNK Last CORBETT		4. DATE OF DEATH Month APRIL Day 22 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 2 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) CLEAR SPRING, DIST.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAC CORBETT		14. MOTHER'S MAIDEN NAME MARY ANN FUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN CORBETT		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Pulmonary tuberculosis, fibroid		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from April 9, 1958 , to April 22, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 12:55 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY ST PAULS CEM.		22d. LOCATION (City, town, or county) (State) NEAR CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i> ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR APR 28 '58 24b. REGISTRAR'S SIGNATURE <i>Archie Cohen</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. PLACE OF DEATH		2. CITY OR TOWNSHIP AND COUNTY		3. COUNTY	
4. NAME OF DECEASED		5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS		9. RACE	
10. DATE OF DEATH		11. TIME OF DEATH		12. CAUSE OF DEATH	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. SEX AT BIRTH	
16. PLACE OF DEATH		17. DATE OF DEATH		18. TIME OF DEATH	
19. PLACE OF BIRTH		20. DATE OF BIRTH		21. SEX AT BIRTH	
22. PLACE OF DEATH		23. DATE OF DEATH		24. TIME OF DEATH	
25. PLACE OF BIRTH		26. DATE OF BIRTH		27. SEX AT BIRTH	
28. PLACE OF DEATH		29. DATE OF DEATH		30. TIME OF DEATH	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. SEX AT BIRTH	
34. PLACE OF DEATH		35. DATE OF DEATH		36. TIME OF DEATH	
37. PLACE OF BIRTH		38. DATE OF BIRTH		39. SEX AT BIRTH	
40. PLACE OF DEATH		41. DATE OF DEATH		42. TIME OF DEATH	
43. PLACE OF BIRTH		44. DATE OF BIRTH		45. SEX AT BIRTH	
46. PLACE OF DEATH		47. DATE OF DEATH		48. TIME OF DEATH	
49. PLACE OF BIRTH		50. DATE OF BIRTH		51. SEX AT BIRTH	
52. PLACE OF DEATH		53. DATE OF DEATH		54. TIME OF DEATH	
55. PLACE OF BIRTH		56. DATE OF BIRTH		57. SEX AT BIRTH	
58. PLACE OF DEATH		59. DATE OF DEATH		60. TIME OF DEATH	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. SEX AT BIRTH	
64. PLACE OF DEATH		65. DATE OF DEATH		66. TIME OF DEATH	
67. PLACE OF BIRTH		68. DATE OF BIRTH		69. SEX AT BIRTH	
70. PLACE OF DEATH		71. DATE OF DEATH		72. TIME OF DEATH	
73. PLACE OF BIRTH		74. DATE OF BIRTH		75. SEX AT BIRTH	
76. PLACE OF DEATH		77. DATE OF DEATH		78. TIME OF DEATH	
79. PLACE OF BIRTH		80. DATE OF BIRTH		81. SEX AT BIRTH	
82. PLACE OF DEATH		83. DATE OF DEATH		84. TIME OF DEATH	
85. PLACE OF BIRTH		86. DATE OF BIRTH		87. SEX AT BIRTH	
88. PLACE OF DEATH		89. DATE OF DEATH		90. TIME OF DEATH	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. SEX AT BIRTH	
94. PLACE OF DEATH		95. DATE OF DEATH		96. TIME OF DEATH	
97. PLACE OF BIRTH		98. DATE OF BIRTH		99. SEX AT BIRTH	
100. PLACE OF DEATH		101. DATE OF DEATH		102. TIME OF DEATH	

BUREAU V. S.

APR 28 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5993

CERTIFICATE OF DEATH

Reg. Dist. No. 05038

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write WHEELERSPORT)	c. LENGTH OF STAY IN 1b 7 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEITERSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) WHEELERSPORT SANITARIUM		d. STREET ADDRESS RT. #5 HAGERSTOWN	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ELLA First SUSAN Middle CRAIG Last		4. DATE OF DEATH APRIL Month 23 Day 19 Year 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME AARON MORGRETT	
14. MOTHER'S MAIDEN NAME JANE MAY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. JEAN BREITWEISER Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 14 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 14 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec , 19 57 , to 23 April , 19 58 , that I last saw the deceased alive on 23 April , 19 58 , and that death occurred at 4:50 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Steenhaak		ADDRESS (Street, city or town, state) 286 Patomac Street DATE SIGNED 25 April 58	
PHYSICIAN'S NAME (Type) PAUL HANIK, M.D.		WHEELERSPORT, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/26/58	22c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEM.	22d. LOCATION (City, town, or county) (State) WAYNESBORO PENNA.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Korman ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR PR 2 9 '58 24b. REGISTRAR'S SIGNATURE Al. Leach	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. MARITAL STATUS		7. CAUSE OF DEATH		8. MANNER OF DEATH	
HOME		MALE		45		WHITE		LABORER		MARRIED		HEART DISEASE		NATURAL	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK	
APR 29 1958		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU X. B.

APR 29 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1101 OAK HILL AVE.	
3. NAME OF DECEASED (Type or print) First MARY Middle MARTHA Last DANZER		4. DATE OF DEATH Month APRIL Day 20 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN IRVIN BITNER		14. MOTHER'S MAIDEN NAME ELIZABETH ALICE NEWCOMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-70054	
17. INFORMANT MR. WILLIAM A. DANZER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days? Unknown.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Fibroid pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-13, 1943 , to 4-20, 1958 , that I last saw the deceased alive on 4-20, 1958 , and that death occurred at 9:06 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington Street DATE SIGNED 4:21:58 ACTUAL SIGNATURE John H. Hornbaker M.D. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Hornmont		24a. REC'D BY REGISTRAR DATE APR 25 '58	
24b. REGISTRAR'S SIGNATURE W. J. Hornmont			

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
APR 25 1933		BALTIMORE		BALTIMORE		MD		USA		APR 25 1933		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM		LABORATORY		PATHOLOGICAL		MICROSCOPIC	
HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		ANGINA PECTORIS		NO		NO		NO		NO		NO	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION	
APR 25 1933		BALTIMORE		BALTIMORE		MD		USA		APR 25 1933		BALTIMORE		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

APR 25 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5041 CERTIFICATE OF DEATH

Reg. Dist. No.

05040

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE N. S. Carolina b. COUNTY Anderson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home		d. STREET ADDRESS 77 X-3	
3. NAME OF DECEASED (Type or print) First Maggie Middle Seraptia Last Davis		4. DATE OF DEATH Month April Day 16 , Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8m 1898
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		10b. KIND OF BUSINESS OR INDUSTRY textile industry	
11. BIRTHPLACE (State or foreign country) Henderson Co., N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ezekial Sentell		14. MOTHER'S MAIDEN NAME Sallie J. Justus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 251-09-1931	
17. INFORMANT Edna Shope, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Metastatic Carcinoma Large Bowel DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Approx 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-26 , 19 57 , to 4-16 , 19 58 , that I last saw the deceased alive on 4-10 , 19 58 , and that death occurred at 4 p.m. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell		ADDRESS (Street, city or town, state) 145 W Washington St Hagerstown Md	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		DATE SIGNED 4/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-19-58	
22c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery		22d. LOCATION (City, town, or county) (State) Gastonia, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR APR 21 58		24b. REGISTRAR'S SIGNATURE W. S. Couch	

BUREAU V. S.

APR 21 1958

RECEIVED

5042 CERTIFICATE OF DEATH

05041

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 17 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		d. STREET ADDRESS R. F. D. # 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ZEBULON Middle Tilden Last DE HART, SR.		4. DATE OF DEATH Month April Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1887
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 7 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Patrick County, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Starrel Rufus De Hart	
14. MOTHER'S MAIDEN NAME Lawsey Adeline Bowers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO. 705-10-6781		17. INFORMANT Mrs. Violet F. De Hart Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Aortic Aneurysm 451X DUE TO arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Emphysema			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 yrs. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from June 20 , 19 52 , to April 15 , 19 58 , that I last saw the deceased alive on April 15 , 19 58 , and that death occurred at 8:15 M., from the causes and on the date stated above.	
ACTUAL SIGNATURE Frederick H. Hager		DATE SIGNED 1594 Washington & Hagerstown Rd 4/16/58	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4/18/1958		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
22d. LOCATION (City, town, or county) (State) Hagerstown Maryland		23. FUNERAL DIRECTOR'S SIGNATURE H. Franklin Hager ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5094

CERTIFICATE OF DEATH

05042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R # 5</u>		d. STREET ADDRESS <u>R # 5</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>VIRGINIA</u> Last <u>DELAUTER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Uriah M. Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Hessong</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Forney Delauter</u>		Address <u>R # 5 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis---duration 1 year</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 1957, to <u>April 11</u> , 1958, that I last saw the deceased alive on <u>April 11</u> , 1958, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>4/14/58</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>100 Professional Arts Bldg.</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>		ADDRESS <u>1601 Penna. Ave.</u>	24a. REC'D BY REGISTRAR DATE <u>APR 16 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

BUREAU V. 3

APR 16 1958

RECEIVED

5043
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				/d. STREET ADDRESS WILLIAMSPORT MD. ROUTE 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ELIZABETH EASTERDAY				4. DATE OF DEATH Month Day Year APRIL 15 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 24 1873	
9. AGE (In years last birthday) 84.5		10. IF UNDER 1 YEAR Months Days Hours Min. 21		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LAPPANS WASH. CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ISAAC GROFF				14. MOTHER'S MAIDEN NAME AMANDA SUMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address DAVID S. EASTERDAY BOONSBORO MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 2 , 19 58 , to April 15 , 19 58 , that I last saw the deceased alive on April 14 , 19 58 , and that death occurred at 4 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro - Ind DATE SIGNED 4-17-58 ACTUAL SIGNATURE G. W. HeVan M.D. Boonsboro - Ind PHYSICIAN'S NAME (Type) G. W. HeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 17 1958		22c. NAME OF CEMETERY OR CREMATORY MANOR CEMETERY NEAR TILGHMANTON WASH. CO. MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS East 2nd St. Boonsboro Md.				24a. REC'D BY REGISTRAR DATE APR 22 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ADMIN BOMD

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

File No. 114

BUREAU V. S.

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5044

CERTIFICATE OF DEATH

Reg. Dist. No. 05044

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. STREET ADDRESS RD 1 - Greencastle	
3. NAME OF DECEASED (Type or print) First ALMA Middle MAE Last FAHRNEY		4. DATE OF DEATH April 10 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1912
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Windsor Shoe Co.		10b. KIND OF BUSINESS OR INDUSTRY General Work	
11. BIRTHPLACE (State or foreign country) Antrim Twp., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Poper		14. MOTHER'S MAIDEN NAME Viola Statler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Ralph Fahrney Address RD 1 Greencastle, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Carcinoma of Ovary DUE TO (b) & Metastasis to Cerebrum DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 10, 1958 to 10 Apr., 1958 that I last saw the deceased alive on 10 Apr., 1958 , and that death occurred at 5 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sw. Webster		DATE SIGNED 11 Apr. 58	
PHYSICIAN'S NAME (Type) PAUL F. WEBSTER, M.D.		GREENCASTLE, PENNA.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/13/58	22c. NAME OF CEMETERY OR CREMATORY Grindstone Hill	22d. LOCATION (City, town, or county) (State) Franklin Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Minnich - Greencastle, Pa.		24a. REC'D BY REGISTRAR DATE APR 14 '58	24b. REGISTRAR'S SIGNATURE Al. Leach

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
OCCASION OF DEATH [Faint handwritten occasion]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF NEXT OF KIN [Faint handwritten signature]		SIGNATURE OF BURIAL OFFICER [Faint handwritten signature]	

RECEIVED
 APR 14 1938
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5995 CERTIFICATE OF DEATH

Reg. Dist. No.

05045

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 42 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 16 Summer St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Summer St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle WATTS Last FALES		4. DATE OF DEATH Month April Day 20 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Bedford, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Henry Bell		14. MOTHER'S MAIDEN NAME Elizabeth Ann Bower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Eliz. Boppe		Address 734 W. Franklin, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation		INTERVAL BETWEEN ONSET AND DEATH Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19, 19 58 , to April 20, 19 58 , that I last saw the deceased alive on April 19, 19 58 , and that death occurred at 7:00A AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		ADDRESS (Street, city or town, state) M.D. 136 N. Potomac St. Hagerstown, Maryland	
DATE SIGNED April 21, 1958			
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		ADDRESS 1601 Penna. Ave.	
DATE APR 22 '58		24b. REGISTRAR'S SIGNATURE W. A. H. H. H.	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. E.

APR 22 1958

RECEIVED

5445 CERTIFICATE OF DEATH

05046

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 North Mulberry Street</u>				d. STREET ADDRESS <u>118 North Mulberry Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Hartle</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1874</u>		9. AGE (In years last birthday) <u>84 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.	
					Months <u>1</u> Days <u>26</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Near Upton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bemistouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>214-09-3942</u>		17. INFORMANT Address <u>Mary E. Pentz, Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Crooney Torsion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u>Enter Torsion Heart Tumor</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-12-58</u> , to <u>4-12-58</u> , that I last saw the deceased alive on <u>4-12-58</u> , 19 <u>58</u> , and that death occurred on <u>4-12-58</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. E. W. Ditt</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>4/13/58</u>			
PHYSICIAN'S NAME (Type) <u>S. E. W. Ditt</u>				M.D. <u>Hagerstown Md</u> <u>4/13/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Puzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Q. L. Smith</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION
10. RACE
11. COLOR
12. SEX OF DECEASED
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[Handwritten signatures and notes]

RECEIVED
APR 15 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. That please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5046

CERTIFICATE OF DEATH

05047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>24 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. STREET ADDRESS <u>160 W. Washington St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>LAWRENCE</u> Last <u>GOFF</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1958</u>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert C. Goff</u>		14. MOTHER'S MAIDEN NAME <u>Nancy L. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert C. Goff-160 W. Washington St.</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis of prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>762.5</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH 24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 24 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/27, 1958</u> to <u>4/28, 1958</u> , that I last saw the deceased alive on <u>4/28/58</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Young, M.D.</u>		ADDRESS (Street, city or town, state) <u>302 N. Prince St. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Young, M.D.</u>		DATE SIGNED <u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alberich</u>			

2081224 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove casket papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5996

CERTIFICATE OF DEATH

05048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		c. LENGTH OF STAY IN 1b 72 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 S. Artizan St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Elmer Last Gossard		4. DATE OF DEATH Month April Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20 1885
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Tannery	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME David Elsworth Gossard		14. MOTHER'S MAIDEN NAME Emma Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 03 1949	
17. INFORMANT Mrs. Pauline Downey Sharpshurg Md RFD #1		Address Taylor's Landing	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH None	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/2/58 to 4/3/58 , that I last saw the deceased alive on 4/3/58 , 19 , and that death occurred at 9 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Young		M.D. William Spaulding	
PHYSICIAN'S NAME (Type) Ralph F. Young		DATE SIGNED 4/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7-58	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith L. Leaf Williamsport Md		24a. REC'D BY REGISTRAR DATE APR 8 '58	
24b. REGISTRAR'S SIGNATURE Rebecca			

CERTIFICATE OF DEATH

202



BUREAU V. E.

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05049

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>48 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>260 S. Mulberry St.</u>		d. STREET ADDRESS <u>260 S. Mulberry St</u>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Stanley</u> Last <u>Grimes</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobiles</u>	
11. BIRTHPLACE (State or foreign country) <u>Shanktown Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Amos Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lochbaum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>214-09-2306</u>	
17. INFORMANT <u>Mrs. Pearl Grimes</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma, pulmonary emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>58</u> , to <u>April 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>58</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. J. Layman, M.D.</u>		ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>4/24/58</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman</u>		<u>Hagerstown</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shanktown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Big Pool Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

Name of Deceased		Place of Birth	
William A. Smith		Baltimore, Maryland	
Age		Sex	
65 years		Male	
Date of Death		Cause of Death	
April 28, 1958		Heart Disease	
Place of Death		Occupation	
Home		None	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

Name of Informant		Relationship to Deceased	
John A. Smith		Son	
Address of Informant		Date of Report	
123 Main St, Baltimore, MD		April 29, 1958	
Signature of Informant		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. E.

APR 28 1958

RECEIVED

548 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Hamby</u> Middle <u>Hamby</u> Last				4. DATE OF DEATH <u>April</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 15 1869</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water Meter Repair Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cavetown - Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>JAMES Hamby</u>				14. MOTHER'S MAIDEN NAME <u>MARY ROBINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Ruth Shockey</u> Address <u>1226 Wabash, Hagerstown</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema and congestion</u> DUE TO <u>527.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ATELECTASIS</u> DUE TO <u>Pulmonary Emphysema</u> (c) <u>10 YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 days</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ATHEROSCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN 29</u> , 19 <u>58</u> , to <u>April 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>58</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Euvaristo R. Landizabal</u> M.D.				ADDRESS (Street, city or town, state) <u>Western Md State Hospital</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Euvaristo R. Landizabal</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APRIL 10</u>		<u>REST HAVEN</u>		<u>HAGERSTOWN, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ANDREW K. COFFMAN - HAGERSTOWN</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.
APR 10 1958

RECEIVED
APR 10 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5049 CERTIFICATE OF DEATH

Reg. Dist. No. 302

05051

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>8 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>523 Gordon Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE</u> First Middle Last <u>JENKINS</u> <u>HARR</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>3</u> <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 24, 1917</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harvey H. Heyser, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Helen Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Phil I. Harr</u> <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of floor of mouth</u> <u>143x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage from floor of mouth</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 14, 1958</u> , to <u>April 3, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>1:57 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>251 E. Baltimore St.</u> DATE SIGNED <u>4-4-58</u>							
ACTUAL SIGNATURE <u>Hugo A. Sacchet</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Hugo A. Sacchet, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royer</u>			ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE <u>APR 7 '58</u> <u> </u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5050 CERTIFICATE OF DEATH

05052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG POOL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Co. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ELIZABETH HOLLAND</u>		4. DATE OF DEATH Month Day Year <u>APRIL 6, 1958</u> 19	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. Co. Mo.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH L. HOLLAND</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE OTTO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS. C. E. HUNTER BERKELEY SPRING, W.V.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 782.4 DUE TO (b) <u> </u> DUE TO (c) <u> </u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 19, 1958</u> to <u>April 6, 1958</u> that I last saw the deceased alive on <u>April 5, 1958</u> , and that death occurred at <u>291</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/6/58</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>		22d. LOCATION (City, town, or county) (State) <u>AGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann C. Hunter Berkeley Springs, W.V.</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Use this form

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. 8

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05053

5051

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Hr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK DAVID HOLLYDAY</u>				4. DATE OF DEATH Month Day Year <u>April 20 1958 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 1884</u>	9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sherley Bldg</u>		11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hollyday</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Hoffmaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>215-18-1328</u>		17. INFORMANT Address <u>Mrs Clara E. Hollyday 707 Forest St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x DIABETES MELLITUS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>5415</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>4-19-58</u> , 19 <u>58</u> , to <u>4-20-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-20-58</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul Harrison</u> M.D. <u>318 North Potomac - Hagerstown</u> ACTUAL SIGNATURE Paul Harrison, M.D. - 318 N. Potomac St.-Hagerstown, Md. 4-22-58 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al Hesch</u>			

BUREAU V. S.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5097

CERTIFICATE OF DEATH

05054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Mr RFD1</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pinesburg</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Jane</u> Last <u>Teach</u> <u>Hose</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bolivia Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Ephriam</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Edythe Stuck</u> Address <u>Pinesburg Williamsport Md RFD 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central vascular Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> to <u>April 9 1958</u> that I last saw the deceased alive on <u>April 9 1958</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Haak</u>				DATE SIGNED <u>11 April 58</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK</u>				ADDRESS (Street, city or town, State) <u>28 W. Patomac Street Williamsport, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith L. Huff</u>				ADDRESS <u>Williamsport Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

INVESTIGATION
RECORDED

BUREAU V. S.

APR 14 1958

RECEIVED

5052 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle FREDERICK Last HOUSE				4. DATE OF DEATH Month April Day 12 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boolder				10b. KIND OF BUSINESS OR INDUSTRY Hag Shoe Co		11. BIRTHPLACE (State or foreign country) Md. Burkettsville-Fred. Co.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel House				14. MOTHER'S MAIDEN NAME E mma Metz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Susan House-128 High St.-Hagers.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							
INTERVAL BETWEEN ONSET AND DEATH Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 6, 1958 to Apr. 12, 1958 , that I last saw the deceased alive on April 12, 1958 , and that death occurred at 10:30A , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.A. Bell				DATE SIGNED 119 North Potomac Street, 4-14-58			
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58		22c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		22d. LOCATION (City, town, or county) (State) Funkstown-Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Goffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR DATE APR 16 '58		24b. REGISTRAR'S SIGNATURE Alfred Lewis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1953

RECEIVED

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM HARRISON		AGE 7 years		SEX Male		RACE White		RELIGION Roman Catholic		MARRIAGE Married	
PLACE OF BIRTH Baltimore, Maryland		DATE OF BIRTH Oct. 11, 1902		DATE OF DEATH Apr. 24, 1908		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Typhoid fever		MANNER OF DEATH Natural	
PLACE OF DEATH Baltimore, Maryland		DATE OF DEATH Apr. 24, 1908		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Typhoid fever		MANNER OF DEATH Natural		MANNER OF DEATH Natural	
NAME OF DECEASED WILLIAM HARRISON		AGE 7 years		SEX Male		RACE White		RELIGION Roman Catholic		MARRIAGE Married	
PLACE OF BIRTH Baltimore, Maryland		DATE OF BIRTH Oct. 11, 1902		DATE OF DEATH Apr. 24, 1908		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Typhoid fever		MANNER OF DEATH Natural	
PLACE OF DEATH Baltimore, Maryland		DATE OF DEATH Apr. 24, 1908		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Typhoid fever		MANNER OF DEATH Natural		MANNER OF DEATH Natural	

RECEIVED
APR 24 1908
BUREAU V. S.

1-24-08
Baltimore, Md.
Baltimore, Md.

5254 CERTIFICATE OF DEATH

05057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. LENGTH OF STAY IN 1b 50yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 136 William Ave			
3. NAME OF DECEASED (Type or print) First Charles Middle Allen Last Jackson				4. DATE OF DEATH Month 4 Day 21 Year 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Gardener		11. BIRTHPLACE (State or foreign country) Shepherdstown W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Bert Jackson				14. MOTHER'S MAIDEN NAME Milly McCann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War 1				16. SOCIAL SECURITY NO. 215-14-1679		17. INFORMANT Walter Jackson Address Rt. #3 Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 21 , 19 58 , to April 21 , 19 58 , that I last saw the deceased alive on April 21 , 19 58 , and that death occurred at 1050 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirshman				M.D. 159 W. Washington St. Hagerstown Md DATE SIGNED 4/23/58			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson				ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR DATE APR 28 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968	
PLACE OF DEATH		CITY		COUNTY		STATE		FEDERAL DISTRICT	
St. Elizabeth's Hospital		Baltimore		Baltimore		Maryland		District of Columbia	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
Suicide by gunshot		Suicide		None		High School		Catholic	
DETAILS OF DEATH		HISTORY OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
Patient was admitted to St. Elizabeth's Hospital on April 3, 1968, with a diagnosis of depression. He was found in his room on April 4, 1968, with a gunshot wound to the chest.		Patient had a history of depression and had been treated with antidepressants. He had been in the hospital for several days prior to his death.		Patient had no previous major illnesses.		Patient was treated with antidepressants and received psychological counseling.		Autopsy was performed on April 5, 1968, and revealed a gunshot wound to the chest.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		COUNTY	
April 4, 1968		10:00 AM		St. Elizabeth's Hospital		Baltimore		Baltimore	

RECEIVED
APR 28 1968
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5755

CERTIFICATE OF DEATH

Reg. Dist. No.

302

05058

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>1655 Lauran Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>ELIZABETH</u> Last <u>JENKINS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1958</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20 1876</u>
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr William H. Perkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Warren A. Shuping</u>		Address <u>1655 Lauran Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Chronic sclerotic nephritis with uraemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Arterio Sclerotic Disease of Coronary & Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>47</u> to <u>April 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>58</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dalton M. Welty</u>		ADDRESS (Street, city or town, state) <u>998 P. Potomac Ave. Hagerstown</u>	
DATE SIGNED <u>4/24/58</u>			
PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Seach</u>	

RECEIVED

APR 28 1958

BUREAU V. 1

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BATTLE ORF 10

556 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>32 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>851 Dewey Ave</u>		e. STREET ADDRESS <u>851 Dewey Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>RUTH</u> Last <u>KAUFFMAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Clugston</u>		14. MOTHER'S MAIDEN NAME <u>Martha Rennecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James W. Kauffman</u>		Address <u>851 Dewey Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphatic Sarcoma Intestine</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hagerstown Md.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-20-58</u> , to <u>4-2-58</u> , that I last saw the deceased alive on <u>4-1-58</u> , 19 <u> </u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		DATE SIGNED <u>4/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten information.

BUREAU V. S.

APR 7 1958

RECEIVED

Form with multiple sections for death certificate data, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten information.

5057 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. STREET ADDRESS 150 S. Mulberry Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle IRENE Last KEEDY				4. DATE OF DEATH Month April Day 28 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1891	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 11 Days 27		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Shelby Clifford Martz				14. MOTHER'S MAIDEN NAME Mary Ellen Werst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-05-6961		17. INFORMANT Address Mr. Clarence G. Keedy Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Adenocarcinoma of colon DUE TO (c) 1 yr. INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 21, 1958 , to April 28, 1958 , that I last saw the deceased alive on April 28, 1958 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clayton A. Hoffman M.D.				ADDRESS (Street, city or town, state) 214 N. Potomac St.			
DATE SIGNED 4/29/58							
PHYSICIAN'S NAME (Type) Clayton A. Hoffman				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Suter				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '58	
				24b. REGISTRAR'S SIGNATURE Clayton A. Hoffman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5557

MD 5557

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH 10/15/1910		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH 11/10/1955		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF DECEASED John Doe	
13. SIGNATURE OF NEXT OF KIN Jane Doe		14. SIGNATURE OF PHYSICIAN Dr. Smith		15. SIGNATURE OF REGISTRAR John Doe		16. SIGNATURE OF CLERK John Doe		17. SIGNATURE OF JUDGE John Doe		18. SIGNATURE OF NOTARY John Doe	
19. SIGNATURE OF DECEASED John Doe		20. SIGNATURE OF NEXT OF KIN Jane Doe		21. SIGNATURE OF PHYSICIAN Dr. Smith		22. SIGNATURE OF REGISTRAR John Doe		23. SIGNATURE OF CLERK John Doe		24. SIGNATURE OF JUDGE John Doe	
25. SIGNATURE OF DECEASED John Doe		26. SIGNATURE OF NEXT OF KIN Jane Doe		27. SIGNATURE OF PHYSICIAN Dr. Smith		28. SIGNATURE OF REGISTRAR John Doe		29. SIGNATURE OF CLERK John Doe		30. SIGNATURE OF JUDGE John Doe	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

5058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 549 Maryland Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELMER Middle PAUL Last KUNKLEMAN				4. DATE OF DEATH Month April Day 12 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1911	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Shippensburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Kunkleman				14. MOTHER'S MAIDEN NAME Mae Ott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-3281		17. INFORMANT Mrs. Paul Kunkleman Address Hagerstown, Md. 704 Claire St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic glomerulonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gastric ulcer							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29, 1958 , to April 12, 1958 , that I last saw the deceased alive on April 11, 1958 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph C. Crisp MD.				DATE SIGNED April 16, 1958			
PHYSICIAN'S NAME (Type) JOSEPH C. CRISP MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORY E.U.B. Church Cemetery		22d. LOCATION (City, town, or county) (State) Cleversburg, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.				ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 16 1958	
				24b. REGISTRAR'S SIGNATURE Wm. G. Host J. Pres.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

APR 16 1953

RECEIVED

5059 CERTIFICATE OF DEATH

Reg. Dist. No.

05062

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2216 Rowland Rd		d. STREET ADDRESS 12216 Rowland Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Agnes Young Long		4. DATE OF DEATH Month April Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 11 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) St. James Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harry Young		14. MOTHER'S MAIDEN NAME Henrietta Coffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Carnochan		Address 2216 Rowland Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Co Artery Lumen Block DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17/58 to 4/18/58 19 58 , that I last saw the deceased alive on 4/18/58 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Calvin F. Young		ADDRESS (Street, city or town, state) William F. Coffman	
PHYSICIAN'S NAME (Type) William F. Coffman		DATE SIGNED 4/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-21-58	22c. NAME OF CEMETERY OR CREMATORY Rose hill	22d. LOCATION (City, town, or county) (State) Hagerstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS 40 E Antietam	
24a. REC'D BY REGISTRAR APB 23 '58		24b. REGISTRAR'S SIGNATURE William F. Coffman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HAGERSTOWN MD

BUREAU V. S.

APR 23 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5960 CERTIFICATE OF DEATH

Reg. Dist. No. 05063

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		d. STREET ADDRESS 34 N. Main St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Clinton Last Masters		4. DATE OF DEATH Month April Day 11 , Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1893
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY grocery store	
11. BIRTHPLACE (State or foreign country) Greensburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Masters		14. MOTHER'S MAIDEN NAME Effie M. Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 199-01-8716	
17. INFORMANT Mrs. Rachel Masters		Address Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Brondiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO Arterio Sclerotic Heart (c)		INTERVAL BETWEEN ONSET AND DEATH one minute 10 yr 10 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 30, 1954 to April 11, 1958 , that I last saw the deceased alive on April 10, 1954 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE G.A. Kohler M.D. Smithsburg Md. 4/11/58 PHYSICIAN'S NAME (Type) G.A. KOHLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-13-58	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Smithsburg, Md.	
24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE W. P. Smith	

BUREAU V. S.

APR 14 1958

RECEIVED
APR 14 1958

5061

CERTIFICATE OF DEATH

Reg. Dist. No.

65064

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 109 Fairground Ave.,		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Catharine Last Middlekauff		4. DATE OF DEATH Month 4 Day 21 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1879
9. AGE (In years last birthday) 79 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Hancock, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Montgomery		14. MOTHER'S MAIDEN NAME Mary Manning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Guy Harbaugh		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 19 57 to April 21, 19 58 , that I last saw the deceased alive on 4/20 , 19 58 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Harbaugh		ADDRESS (Street, city or town, state) 318 N. Potomac DATE SIGNED 4-21-58	
PHYSICIAN'S NAME (Type) Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4-23-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE W. Harbaugh	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1958

RECEIVED

562 CERTIFICATE OF DEATH

05065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 34 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 RIDGE AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILDRED Middle ANN Last MILLER				4. DATE OF DEATH Month APRIL Day 21 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAC NEWTON PRESTON				14. MOTHER'S MAIDEN NAME MARY ELIZABETH REEDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. HELEN DRIGGERS HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic heart disease & DUE TO (b) Cerebral thrombosis - due general - 1 yr. DUE TO (c) 13x1 arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large hiatal hernia; Advanced pulm. Fibrosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 10, 1957 , to Apr. 21, 1958 , that I last saw the deceased alive on Apr. 19, 1958 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington Street DATE SIGNED 4/22/58 ACTUAL SIGNATURE Edward W. Ditto M.D. Edward W. Ditto PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/24/58		22c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM.		22d. LOCATION (City, town, or county) (State) WILLIAMSPORT MD.	
23. FUNERAL DIRECTOR'S SIGNATURE A. J. Normant ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 15 1958	
PLACE OF DEATH AT HOME		AGE 68	
SEX MALE		RACE WHITE	
BIRTH DATE JAN 15 1890		BIRTH PLACE BALTIMORE, MD	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
DATE OF BURIAL JAN 17 1958		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	
DATE OF SIGNATURE JAN 15 1958		DATE OF SIGNATURE JAN 15 1958	

BUREAU V. S.

APR 25 1958

RECEIVED

5063 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 726 Interval Road			
3. NAME OF DECEASED (Type or print) First ROSIE Middle CATHERINE Last MISNER				4. DATE OF DEATH Month April Day 16 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 10 Days 9 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James O. Green				14. MOTHER'S MAIDEN NAME Sarah Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-3380		17. INFORMANT Address Mrs. Lola C. Leiboldt Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 Days 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-20 , 19 57 , to 4-16 , 19 58 , that I last saw the deceased alive on 4-15 , 19 58 , and that death occurred at 5:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg Md. DATE SIGNED 4-16-58							
ACTUAL SIGNATURE Charles F. Hess M.D.							
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rye				24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-100

NAME OF DECEASED JAMES H. HARRISON		SEX Male		AGE 45	
DATE OF DEATH April 21, 1958		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
TIME OF DEATH 10:00 AM		PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH April 21, 1913	
OCCUPATION Clerk		MARITAL STATUS Married		NUMBER OF CHILDREN 3	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)	
SIGNATURE OF CORONER (Signature)		SIGNATURE OF JURY (Signature)		SIGNATURE OF DEATH CERTIFICATE (Signature)	

BUREAU V. S.

APR 21 1958

RECEIVED

5064 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>652 West Washington Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Russel</u> Last <u>Mullenix</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commander Of Local Unit</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Volunteers America</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon Mullenix</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-9943</u>	
17. INFORMANT <u>Mrs Grace Mullenix</u>		Address <u>652 W. Washington St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 22, 58</u> , 19 <u> </u> , to <u>April 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>58</u> , and that death occurred at <u>8:00P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.A. Bell</u>		DATE SIGNED <u>4-11-58</u>	
PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>		<u>Hagerstown, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>R.A. Bell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, page 3 of 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Poole Md.</u>			c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Poole Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Big Poole</u>				d. STREET ADDRESS <u>Big Poole</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Enoch</u> Middle <u>Washington</u> Last <u>Newlin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22 1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Dorsey Newlin</u>				14. MOTHER'S MAIDEN NAME <u>Bertie Brill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 28 5835</u>		17. INFORMANT Address <u>Mrs. Marie Newlin Big Poole Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-29-58</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport Md</u>				24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5758

STATE OF MASS.
COUNTY OF
CITY OF

DECEASED
AGE
SEX
MARRIAGE

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

SIGNATURE OF EXAMINER

DATE

CERTIFICATE OF DEATH

BUREAU V. 3

APR 14 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1843. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Co. Hospital		/ d. STREET ADDRESS 10 E. Chestnut St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Virginia Last Ohler		4. DATE OF DEATH Month 4 Day 27 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS. Hours 63 Min. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Lovettsville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Virts		14. MOTHER'S MAIDEN NAME Loretta E. Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leonard K. Ohler		Address Funkstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Apr 28'58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-30-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE W. E. Leach	

99

1

2

1 MD 00 I 0 AP VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 MD 00 I 0 AP VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5667

CERTIFICATE OF DEATH

05072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN IB <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>705 So Potomac St</u>				d. STREET ADDRESS <u>705 S. Potomac Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jerome</u> Middle <u>NMN.</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Miladeburg Penna.</u>	
13. FATHER'S NAME <u>John Powell</u>				14. MOTHER'S MAIDEN NAME <u>Ellen L. Orris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>212-14-7137</u>			
17. INFORMANT Address <u>Mrs. Irene Foreman, 705 S. Potomac St</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 422.1 DUE TO <u>Arterio Sclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>28 Mar</u> , 19 <u>58</u> , to <u>4 Apr</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2 Apr</u> , 19 <u>58</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				DATE SIGNED <u>5 Apr 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 18

BUREAU V. S.

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5068

CERTIFICATE OF DEATH

Reg. Dist. No.

05073

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 757 GUILFORD AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last ROHRER		4. DATE OF DEATH Month APRIL Day 17 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COAL MERCHANT OWN YARD		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HENRY ROHRER		14. MOTHER'S MAIDEN NAME MARY FUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-9217	
17. INFORMANT MRS. ANNIE L. ROHRER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 55 to April 17 , 19 58 , that I last saw the deceased alive on April 17 , 19 58 , and that death occurred at 8:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St. Hagerstown, Maryland DATE SIGNED 4/19/58			
ACTUAL SIGNATURE B. B. Kneisley		M.D. 148 West Washington St. Hagerstown, Maryland	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/20/58	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Korman		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE Dee...	

BUREAU V. S.

APR 21 1938

RECEIVED

05074

5099 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BIG SPRING, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL BIG SPRING, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE RURAL		/d. STREET ADDRESS NONE RURAL	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First M. Middle ROWLAND Last		4. DATE OF DEATH APRIL Month 6 Day 19 Year 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT II, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	11. BIRTHPLACE (State or foreign country) MILLSTONE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEWIS SHOEMAKER		14. MOTHER'S MAIDEN NAME CARRIE WELLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS CARRIE E. MURRAY Address BIG SPRING, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Endocarditis 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 1, 1957 to Apr 6, 1958 , that I last saw the deceased alive on April 5, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		DATE SIGNED 4/7/58	
PHYSICIAN'S NAME (Type) David R. Brewer		md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 8, 1958	22c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE CEM.	22d. LOCATION (City, town, or county) (State) MILLSTONE MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		24. REC'D BY REGISTRAR DATE APR 10 '58	
ADDRESS CLEAR SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arbeauch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

APR 10 1958

RECEIVED

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH APR 10 1958	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

MADE IN MARYLAND

5100 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 West Baltimore St.		d. STREET ADDRESS 27 West Baltimore St.	
3. NAME OF DECEASED (Type or print) First VICTOR Middle HARRISON Last ROWLAND		4. DATE OF DEATH Month April Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Colonial		10b. KIND OF BUSINESS OR INDUSTRY Hard Wood Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Rowland		14. MOTHER'S MAIDEN NAME Ardella Suman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-30-9510	
17. INFORMANT Mrs. Bessie M. Rowland-27 W. Baltimore		Address Funkstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Concussion of Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/21/58 to 4/23/58 , that I last saw the deceased alive on 4/21/58 , and that death occurred at 28 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Ralph F. Young M.D.		Williamsport, Maryland 4-23-58	
PHYSICIAN'S NAME (Type) Ralph F. Young, M.D.		Williamsport, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-58	
22c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		22d. LOCATION (City, town, or county) (State) Funkstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE APR 28 '58	
24b. REGISTRAR'S SIGNATURE W. H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		UNKNOWN		OTHER		OTHER	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HAIR		EYES		SKIN	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	

BUREAU V. S.

APR 28 1938

RECEIVED

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		UNKNOWN		OTHER		OTHER	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HAIR		EYES		SKIN	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5069 CERTIFICATE OF DEATH

Reg. Dist. No.

05076

1. PLACE OF DEATH a. COUNTY Washington C MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Beechwood Drive		d. STREET ADDRESS 908 Beechwood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Margaret Shank		4. DATE OF DEATH Month Day Year April 29 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1876
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min. 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Leitersburg Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Upton Clopper		14. MOTHER'S MAIDEN NAME Margaret Lowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT R. Karl Shank		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis 392 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/22/58 to 4/29/58 , that I last saw the deceased alive on 3/22/58 , and that death occurred at 7:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 135 N. Potomac St Hagerstown Md. 4/29/58	
ACTUAL SIGNATURE J. D. Wilson		PHYSICIAN'S NAME (Type) J. D. Wilson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-58	
22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Leitersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.		ADDRESS 135 N. Potomac St Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE W. L. ...	

100000

CERTIFICATE OF DEATH

Reg. Dist. No.

Name of Deceased Williamson, Anna		Sex Female		Age 38		Date of Birth April 29, 1898		Place of Birth Germany		Cause of Death Heart Disease	
Residence 908 Cheswood Drive		Occupation Housewife		Marital Status Married		Date of Death Dec. 23, 1936		Place of Death Home		Time of Death 10:30 AM	
Name of Informant Anna Williamson		Relationship Wife		Signature <i>[Signature]</i>		Date Dec. 23, 1936		Place Home		Signature <i>[Signature]</i>	
Name of Physician Dr. J. H. Shank		Signature <i>[Signature]</i>		Date Dec. 23, 1936		Place Home		Signature <i>[Signature]</i>		Date Dec. 23, 1936	
Name of Coroner John H. Shank		Signature <i>[Signature]</i>		Date Dec. 23, 1936		Place Home		Signature <i>[Signature]</i>		Date Dec. 23, 1936	
Name of Registrar John H. Shank		Signature <i>[Signature]</i>		Date Dec. 23, 1936		Place Home		Signature <i>[Signature]</i>		Date Dec. 23, 1936	

100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg		c. LENGTH OF STAY IN 1b 30 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithsburg #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Mae Last Shockey		4. DATE OF DEATH Month April Day 10 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1872
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Ringgold Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Barkdoll		14. MOTHER'S MAIDEN NAME Julianne Rodgers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Richard Newcomer, Smithsburg Md., #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 mo. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 58 , to 4-10 , 19 58 , that I last saw the deceased alive on 4-10 , 19 58 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess M.D.		ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 4-11-58	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/58	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Howe		24a. RECORDING REGISTRAR'S SIGNATURE Walter J. Howe	
ADDRESS Waynesboro, Pa		DATE APR 14 1958	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING
CERTIFICATE OF DEATH



RECEIVED
BUREAU V. S.

BUREAU V. S.

APR 14 1958

RECEIVED

5970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 50yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 101 W. Church Street			
3. NAME OF DECEASED (Type or print) First Middle Last Amanda Elizabeth Smith				4. DATE OF DEATH Month Day Year April 14 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 1 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Sperryville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fletcher				14. MOTHER'S MAIDEN NAME Unknow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-26-7224		17. INFORMANT Address Mary Wilson N. Jonathan Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 wks DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/30/55 , 19____, to 4/14/58 , 19____, that I last saw the deceased alive on 4/14/58 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 4/16/58							
ACTUAL SIGNATURE Howard N. Weeks, M.D.		Hagerstown, Maryland					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-19-1958	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr		ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 21 1958

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME OF DECEASED: *WILLIAM H. WILSON*
AGE: *70* SEX: *M*
DATE OF BIRTH: *APR 11 1888*
PLACE OF BIRTH: *NEW YORK*
OCCUPATION: *RETIRED*
CAUSE OF DEATH: *HEART DISEASE*
DATE OF DEATH: *APR 18 1958*
PLACE OF DEATH: *AT HOME*
SIGNATURE OF DECEASED: *[Signature]*
SIGNATURE OF WITNESS: *[Signature]*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF REGISTRAR: *[Signature]*

10-10-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells
05079302
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>30 Min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co, Hospital</u>				d. STREET ADDRESS <u>315 West Franklin Street</u>			
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>ADELA</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi S. Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Amanda C. Bricker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mary Royer 42 So Church St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid colon</u> <u>153.3</u> DUE TO <u>Intestinal Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peritonitis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md,</u>				24a. REC'D BY REGISTRAR <u>Apr 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Robert Wells</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH-BATIMORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. S.

APR 7 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05080

5072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Redman</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1 1885</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>	
11. BIRTHPLACE (State or foreign country) <u>Moorefield W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Hunter Redman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Banks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 30 9862</u>	
17. INFORMANT <u>Mr. Alexander Redman Keyser W. Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/12/58</u> , 19 <u>58</u> , to <u>4/13/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/12/58</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Albert L. Leach Williamsport Md</u>		M.D. <u>Albert L. Leach</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leach Williamsport Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Leach</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1958

RECEIVED

5973 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herbert First Middle Last Souders		4. DATE OF DEATH April 14 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Souders		14. MOTHER'S MAIDEN NAME Sarah Monighan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-3692	
17. INFORMANT Edwin Souders		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Ventricular Fibrillation DUE TO (b) Coronary Thrombosis DUE TO (c) 1 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 58 , to 4-14 , 19 58 , that I last saw the deceased alive on 4-13 , 19 58 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Harrison M.D.		ADDRESS (Street, city or town, state) 318 N. POTOMAC ST Hagerstown, Md	
PHYSICIAN'S NAME (Type) Paul Harrison, M.D.		DATE SIGNED 4-14-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-58	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran		22d. LOCATION (City, town, or county) (State) Myersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR APR 17 58	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE W. H. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

APR 17 1923

RECEIVED

Robert L. Minnich & Son, Lexington, Md.

April 16-23

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05082

5074 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 W. Franklin St.</u>		d. STREET ADDRESS <u>506 W. Franklin St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SERENO</u> Middle <u>WESLEY</u> Last <u>SOORS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1896</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Luray, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Laney W. Soors</u>		14. MOTHER'S MAIDEN NAME <u>Kizzie Jane Boyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daniel B. Soors</u>		Address <u>506 W. Franklin St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Palsy in</u> (c) <u>Parasitosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>46 yrs</u> <u>one week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-1-1958</u> to <u>4-7-1958</u> , that I last saw the deceased alive on <u>4-3-1958</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>N. E. W. Smith</u> M.D. <u>Hagerstown Md</u> ADDRESS (Street, City or town, State) <u>Hagerstown Md.</u> DATE SIGNED <u>4/7/58</u> PHYSICIAN'S NAME (Type) <u>N. E. W. Smith</u> <u>Hagerstown Md</u> <u>4/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc.</u>		ADDRESS <u>1601 Penna. Ave. Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. G. Hunt</u>	

5075

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2123 Penna Ave</u>		d. STREET ADDRESS <u>1 2123 Penna Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>FISHER</u> Last <u>SPONSELLER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 20 1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk W.M.R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Clear Spring Wash. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Sponseller</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Steinmetz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edgar A. Sponseller</u>		Address <u>924 Rolling Road Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arterio sclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/26</u> , 19 <u>58</u> , to <u>4/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/26</u> , 19 <u>58</u> , and that death occurred at <u>8:15 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Jennings</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/28/58</u>	
PHYSICIAN'S NAME (Type) <u>George Jennings</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Little Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffmann</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 1 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

JOHN B. COOPER
JAN 19 1900

Name of Deceased		John B. Cooper	
Age		60 years	
Sex		Male	
Race		White	
Date of Death		Jan 19 1900	
Place of Death		At Home	
Cause of Death		Heart Disease	
Occupation		Farmer	
Residence		Rural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Minister		[Signature]	
Signature of Coroner		[Signature]	
Signature of Jury		[Signature]	
Signature of Witnesses		[Signature]	
Signature of Deceased		[Signature]	
Signature of Family		[Signature]	
Signature of Friends		[Signature]	
Signature of Neighbors		[Signature]	
Signature of Community		[Signature]	
Signature of State		[Signature]	
Signature of Nation		[Signature]	
Signature of World		[Signature]	
Signature of Universe		[Signature]	
Signature of God		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5076 CERTIFICATE OF DEATH

05084

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Mo</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>455 West Antietam St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>BRUCE</u> Last <u>STONER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Stoner</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Stoner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-5725</u>	
17. INFORMANT <u>William U. Stoner</u>		Address <u>455 W. Antietam st</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>177X Carcinoma of prostate with</u> IMMEDIATE CAUSE (a) <u>generalized metastases.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 29, 1957</u> to <u>April 6, 1958</u> , that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Crisp MD.</u>		ADDRESS (Street, city or town, state) <u>115 King St., Hagerstown Md.</u>	
DATE SIGNED <u>JOSEPH C. CRISP MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Redman</u>	

APR 10 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5977

CERTIFICATE OF DEATH

05085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 40 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 66 North Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie Elizabeth Swomley First Middle Last		4. DATE OF DEATH April 29 Month Day Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Quincy Township Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward M. Shockey		14. MOTHER'S MAIDEN NAME Emma Baer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Tressa Crawford		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 180x Uremia DUE TO Hypernephroma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 7 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 4/29 , 19 57 , to 4/29 , 19 58 , that I last saw the deceased alive on 4/29 , 19 58 , and that death occurred at M. , from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE D. J. Boyer		ADDRESS (Street, city or town, state) M.D. 135 N. Potomac St. Hag. Md.	
PHYSICIAN'S NAME (Type) David J. Boyer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR MAY 5 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

PLACE OF BIRTH Washington		PLACE OF BIRTH Maryland	
DATE OF BIRTH 1900		DATE OF BIRTH 1900	
PLACE OF DEATH Washington County Hospital		PLACE OF DEATH Washington	
DATE OF DEATH April 29		DATE OF DEATH April 29	
NAME David M. Shoeney		NAME David M. Shoeney	
SEX Male		SEX Male	
RACE White		RACE White	
HOUSE NO. 110		HOUSE NO. 110	
TOWNSHIP Prince Georges		TOWNSHIP Prince Georges	
COUNTY Prince Georges		COUNTY Prince Georges	
STATE Maryland		STATE Maryland	
MARRIAGE Single		MARRIAGE Single	
OCCUPATION Clerk		OCCUPATION Clerk	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MEDICAL HISTORY None		MEDICAL HISTORY None	
SIGNATURE OF PHYSICIAN David M. Shoeney		SIGNATURE OF PHYSICIAN David M. Shoeney	
SIGNATURE OF WITNESS David M. Shoeney		SIGNATURE OF WITNESS David M. Shoeney	
SIGNATURE OF DEATH REGISTRAR David M. Shoeney		SIGNATURE OF DEATH REGISTRAR David M. Shoeney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5078

CERTIFICATE OF DEATH

Reg. Dist. No.

05086

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 WKS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS REID	
3. NAME OF DECEASED (Type or print) HARVEY MASON TROUPE		4. DATE OF DEATH APRIL 10 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1892
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done) RETIRED MACHINIST HELPER RAIL ROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID SCOTT TROUPE		14. MOTHER'S MAIDEN NAME ELLA BOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both when) NO		16. SOCIAL SECURITY NO. 705-10-4619	
17. INFORMANT MRS. FLORENCE TROUPE		Address RT. #6 HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO <i>arterio-sclerotic Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes</i> DUE TO (c) <i>Hypertrophy of the Left Ventricle</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 4 yrs 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1-57 19, to 4-10-1958, that I last saw the deceased alive on 4-10-58, 19, and that death occurred at 4 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>D. W. Deth</i> M.D. <i>Hagerstown Md</i> 4/11/58 PHYSICIAN'S NAME (Type) <i>D. W. Deth</i> <i>Hagerstown Md</i> 4/11/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/13/58	
22c. NAME OF CEMETERY OR CREMATORY LUTHERN CHURCH		22d. LOCATION (City, town, or county) (State) LEITERSBURG MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment</i> ADDRESS <i>Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR DATE APR 15 1958	
24b. REGISTRAR'S SIGNATURE <i>W. J. Norment</i>			

RECEIVED
APR 15 1938
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5979

CERTIFICATE OF DEATH

05087

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>25</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>450 North Prospect Street</u>				d. STREET ADDRESS <u>450 North Prospect Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>George</u> Middle <u>Wesley</u> Last <u>Tullis</u>		4. DATE OF DEATH		Month <u>April</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1881</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Decatur, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Tullis</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-0229</u>		17. INFORMANT <u>Mrs. George W. Tullis, Hagerstown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Arteriosclerotic heart disease with vascular hypertension</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u> <u>27 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 28</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington Street</u> DATE SIGNED <u>4/9/58</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		M.D. <u>Hagerstown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. B. Kneisley</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. F. Kneisley</u>			

BUREAU V. S.

APR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05088	
S. Robert Wells M.D., D.M.E. Wacker Co. Md. 4/21/58										Reg. Dist. No. 302	
5980											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>17 years</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1006 Potomac Ave.</u>					d. STREET ADDRESS <u>1006 Potomac Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSA</u> Middle <u>MARIE</u> Last <u>WAGNER</u>					4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 58</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 8, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Gustav Louis Schroeder</u>					14. MOTHER'S MAIDEN NAME <u>Rebecca Burger</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>220-34-0087</u>		17. INFORMANT <u>Frederick H. Wagner III Los Angeles, Calif.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>54</u> , to <u>April</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 30, 1955</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>4/21/58</u> ACTUAL SIGNATURE <u>Claydon A. Hoffman</u> M.D. PHYSICIAN'S NAME (Type) <u>Claydon A. Hoffman</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4/21/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Frankel</u> Suter-Rouzer Funeral Home Hagerstown, Md.						24a. REC'D BY REGISTRAR DATE <u>APR 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Claydon A. Hoffman</u>			

5981 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memoria l Home				d. STREET ADDRESS 400 Ridge Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RACHAEL Middle NANCY Last WALKER				4. DATE OF DEATH Month April Day 5 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1878		9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Dress Making		11. BIRTHPLACE (State or foreign country) Wardensville, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Walker				14. MOTHER'S MAIDEN NAME Rachael Godlove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-05-6502		17. INFORMANT Mr. Edwin Kershner Address 400 Ridge Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Phlebotrombosis - Femoral Vein DUE TO Senile Heart Disease (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 days 2 hrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18th, 1958 , to April 5th, 1958 , that I last saw the deceased alive on April 5th, 1958 , and that death occurred at 10:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirshman				ADDRESS (Street, city or town, state) DATE SIGNED 159 W. Washington St. Hagerstown Md. 4/7/58			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				159 W. Washington St., Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.				ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 8 '58	
				24b. REGISTRAR'S SIGNATURE Wm. G. Stott			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. SMITH		Male		45		White		1913		Baltimore, Md.		April 7, 1958		Baltimore, Md.		10:30 AM		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	
1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
JAMES H. SMITH		Male		45		White		1913		Baltimore, Md.		April 7, 1958		Baltimore, Md.		10:30 AM		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	

BUREAU V. A.

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5402

CERTIFICATE OF DEATH

05090

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick Rural 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mary Lou Webber		4. DATE OF DEATH 4 20 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1898
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morgan P. Runkles		14. MOTHER'S MAIDEN NAME Mary Ann Leopold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen E. Kaetzel, Knoxville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to 4-20-1958 , that I last saw the deceased alive on 4-20-1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 4-21-58			
ACTUAL SIGNATURE C.E. Pruitt		M.D. Brunswick, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-1958	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE Alb. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

NAME OF DECEASED MORRIS F. HANCOCK		DATE OF DEATH APR 28 1938	
PLACE OF DEATH Baltimore, Maryland		AGE 77	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Methodist	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERVAL 24 hours	
PREVIOUS ILLNESS Hypertension		TREATMENT None	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		POST-MORTEM None	
FAMILY HISTORY None		SOCIAL HISTORY None	
HISTORICAL DATA None		LABORATORY DATA None	
PATHOLOGICAL DATA None		RADIOLOGICAL DATA None	
MICROSCOPICAL DATA None		OTHER DATA None	

MORRIS F. HANCOCK

APR 28 1938

BUREAU V. 1

APR 28 1938

RECEIVED

Baltimore, Maryland

2-23-1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5082 CERTIFICATE OF DEATH

05091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FLINTSTONE</u> <u>01X-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md State Hospital</u>				d. STREET ADDRESS <u>Route 2</u>			
3. NAME OF DECEASED (Type or print) First <u>DEWEY</u> Middle <u>WEIGHT</u> Last <u>WEIGHT</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2 1901</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>MARION WEIGHT</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Potts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-10-20X</u>		17. INFORMANT Address <u>Ruth Weight-Flintstone, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY FIBROSIS AND EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 15</u> , 19 <u>58</u> , to <u>April 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>58</u> , and that death occurred at <u>7:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.				ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>EVARISTO R. LARDIZABAL</u>				<u>HAGERSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Plains Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Piney Plains, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Hofer</u> ADDRESS <u>Chesapeake, Md.</u>				24a. REC'D BY REGISTRAR <u>DAWAY</u> <u>5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one place within 72 hours after death.

5083

CERTIFICATE OF DEATH

Dr. J. H. Beachley

05092

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Cty. Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 77 Wyatt St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John W. Wiley				4. DATE OF DEATH Month Day Year Apr. 3 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 13, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W. M. Rwy Conductor				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Wilson, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Washington Wiley				14. MOTHER'S MAIDEN NAME Mary Elizabeth Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Harry W. Wiley, R #1, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 525x Pneumonia DUE TO Bronchitis (severe) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bi-lateral (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
INTERVAL BETWEEN ONSET AND DEATH 10 yrs 4 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from Apr. 3, 1958 to Apr. 3, 1958 , that I last saw the deceased alive on Apr. 3, 1958 , and that death occurred at Hagerstown, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 4/3/58							
ACTUAL SIGNATURE J. H. Beachley				M.D. J. H. Beachley			
PHYSICIAN'S NAME (Type) J. H. Beachley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-1958		22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) nr Clearspring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 8 '58	
				24b. REGISTRAR'S SIGNATURE Andrew K. Coffman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. E.

APR 8 1958

RECEIVED

Attorney E. G. Gorman, Baltimore, Md.

5103 CERTIFICATE OF DEATH

05093

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75X-3 Rural Southampton Twp</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maugansville Menhite Home</u>		d. STREET ADDRESS <u>RD 3, Shippensburg</u>	
3. NAME OF DECEASED (Type or print) First <u>Salome</u> Middle <u>Witmer</u> Last <u>Witmer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>RR #3 Shippensburg, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Witmer</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Horst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry Witmer, RR #2, Chambersburg, Pa</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive vascular disease due to</u> <u>447X</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19</u> , 19 <u>52</u> , to <u>April 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 19</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) <u>148 West Washington St.,</u> DATE SIGNED <u>4/24/58</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 25, 1958</u>	<u>Rowe Cemetery</u>	<u>Southampton Twp Franklin Co Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sheld H. Zimmerman</u>		24a. REC'D BY REGISTRAR <u>Greenleaf</u> 24b. REGISTRAR'S SIGNATURE <u>April 1 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. DATE OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF CORONER [Faint text]</p>	
<p>15. SIGNATURE OF JUDGE [Faint text]</p>		<p>16. SIGNATURE OF CLERK [Faint text]</p>	



This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the office of the Registrar of the Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05094

Reg. Dist. No.

5984

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 525 E. Franklin St.			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Grace Wood				4. DATE OF DEATH Month Day Year April 2 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Fairfield Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob H. Plank				14. MOTHER'S MAIDEN NAME Jennie Shank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Weldon E. Plank Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO (b) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 4 yrs							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Edward W. Ditto Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR APR 7 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. E. Plank</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

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APR 7 1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05095

Reg. Dist. No. 302

5285

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEE Middle WORLEY Last		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 4 Days 12	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. to President		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company	
11. BIRTHPLACE (State or foreign country) Charlotte, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sidney J. Worley		14. MOTHER'S MAIDEN NAME Lilla B. Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 137-09-9577	
17. INFORMANT Address Mrs. Frances Worley Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Cerebral Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 12 hours 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-14-58 to 4-14-58 that I last saw the deceased alive on 4-14-58 , 19 58 , and that death occurred at 8:00 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Hagerstown Md		DATE HONED 4/15/58	
ACTUAL SIGNATURE [Signature] M.D. [Signature]			
PHYSICIAN'S NAME (Type) [Signature]			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4/16/1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Ponger ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 16 '58	
		24b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05096**

5986

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EAST ANTIETAM STREET		d. STREET ADDRESS 105 EAST ANTIETAM ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE I. YOUNG		4. DATE OF DEATH Month Day Year APRIL 15 1958 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 1 1921
9. AGE (In years last birthday) 36 10/14		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY L AIGLON	
11. BIRTHPLACE (State or foreign country) CHESTNUT GROVE WASH, CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH BUSSARD		14. MOTHER'S MAIDEN NAME BEULAH HOLMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-12-1133	
17. INFORMANT JOSEPH BUSSARD KEEDYSVILLE MD. R.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot (bullet) thru skull into brain 981x DUE TO (.22 calibre revolver) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by husband on sidewalk in front of her apartment home	
20c. TIME OF INJURY Month, Day, Year 7:15 p.m. Apr 15 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sidewalk	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED 4-16-58	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 18 1958	22c. NAME OF CEMETERY OR CREMATORY SAMPLES MANOR CEMETERY	22d. LOCATION (City, town, or county) (State) SAMPLES MANOR MD.
23. FUNERAL DIRECTOR'S SIGNATURE East Funer Home		24a. REC'D BY REGISTRAR APR 22 '58	
ADDRESS Baltimore Md		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

RECEIVED
MAY 1 1938
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. 3

APR 22 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05097

5087

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA - Emergency Room-Hospital				d. STREET ADDRESS 142 South Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle RAGAN Last YOUNG, SR.				4. DATE OF DEATH Month April Day 15 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1904		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S.L.V. Young				14. MOTHER'S MAIDEN NAME Sophia Saum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-3588		17. INFORMANT Mr. Paul R. Young, Jr. Address: St. James College Rd. R#3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot (bullet) thru skull into brain 976X DUE TO (.22 calibre revolver) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with .22 revolver after having shot wife					
20c. TIME OF INJURY Hour 7:15 p.m. Month, Day, Year 4-15 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sidewalk		20f. (City or town) Hagerstown		(County) Wash	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE Al. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
APR 21 1958
BUREAU V. 5

APR 21 1958